

City of Scottsdale Employee Benefits Optional Open Enrollment Form

MARK CHANGES ONLY!

Effective Date: July 1, 2004

If you are keeping the same benefits, do not complete this form, your current benefits will continue through June 30, 2005.

FOR HUMAN RESOURCES USE ONLY

____ Complete
____ Keyed on _____

Received on:

Employee Last Name

First Name, MI

Employee Number

0 0 _____

MEDICAL

- ☐ AETNA OPEN ACCESS EPO (408)
☐ MMSI HEALTH TRADITION PPO (410)
☐ AETNA OPEN CHOICE PPO (418)
☐ WAIVE MEDICAL**
 If you are a full time employee, you must provide proof of other coverage.

Is this a change? ☐ Yes ☐ No

LEVEL of COVERAGE

- ☐ Employee
 AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

DENTAL

- ☐ ASSURANT DENTAL (HMO) (425)
 Dental Office ID# _____***
☐ CITY OF SCOTTSDALE SCOTTSMILES
 PPO DENTAL (420)
☐ NO DENTAL

Is this a change? ☐ Yes ☐ No

LEVEL OF COVERAGE

- ☐ Employee
 AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

SUPPLEMENTAL LIFE INSURANCE

Any current approved life insurance amounts will carry over for 2004/2005. You may apply for new coverage or changes at any time. Forms are located at www.ScottsdaleAZ.gov/jobs/benefacts

CANCER & CRITICAL CARE COVERAGE
 For enrollment or changes call Colonial Life & Accident 1-800-845-7330

**WAIVING MEDICAL COVERAGE

If you are a full time employee, you must provide proof of other coverage in order to waive medical coverage.

***DENTAL OFFICE ID#

The dental office you choose will be applicable for you and your dependents unless you specify a different dental office for your dependents in the dependent section on the back of this form.

ALTERNATIVE MEDICINE

- ☐ ALTERNATIVE HEALTHCARE OPTIONS (431)
☐ NO ALTERNATIVE MEDICINE
 Is this a change? ☐ Yes ☐ No

LEVEL OF COVERAGE

- ☐ Employee
 AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

ENHANCED VISION

- ☐ EYEMED VISION CARE (432)
☐ NO ENHANCED VISION
 Is this a change? ☐ Yes ☐ No

LEVEL OF COVERAGE

- ☐ Employee
 AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

SHORT TERM DISABILITY

WEEKLY BENEFIT (430)

- ☐ NO SHORT TERM DISABILITY
☐ \$100/week (01)
☐ \$200/week (02)
☐ \$250/week (03)
☐ \$300/week (04)
☐ \$350/week (05)
☐ \$400/week (06)
☐ \$500/week (07)

Is this a change? ☐ Yes ☐ No

(Short Term Disability Coverage cannot exceed 70% of your weekly salary)

*DOMESTIC PARTNERSHIP COVERAGE

In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage: In order for an employee to enroll a domestic partner for insurance coverage, both the employee and the domestic partner must complete the Domestic Partnership Affidavit. City of Scottsdale Human Resources must approve the affidavit prior to the commencement of coverage. Those with affidavits already on file do not have to resubmit. The portion of the insurance premium paid by the employee for domestic partner and children of the domestic partner is paid on an after-tax basis. The portion of the premium paid by the City for domestic partner and children of the domestic partner is reported to the Internal Revenue Service as taxable income to the employee. City employees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage.

TWO SIDED FORM – BE SURE TO COMPLETE REVERSE SIDE

Benefits Optional Open Enrollment Form (continued)

DEPENDENTS (LIST ALL DEPENDENTS TO BE ENROLLED IN ANY NEW PLAN)			
Dependent children between ages 19 and 25 must be enrolled in at least six credit hours to be eligible for coverage.			
Spouse Name (Last, First MI)		Date of Birth	Gender
Spouse is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental – If Assurant, Dental Office # (if different from employee): _____ <input type="checkbox"/> Alternative Medicine <input type="checkbox"/> Enhanced Vision			
Domestic Partner's Name* (Last, First MI)		Date of Birth	Gender
Domestic Partner is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental – If Assurant, Dental Office # (if different from employee): _____ <input type="checkbox"/> Alternative Medicine <input type="checkbox"/> Enhanced Vision			
Dependent 1 Name (Last, First MI)		Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child
Dependent 1 is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental – If Assurant, Dental Office # (if different from employee): _____ <input type="checkbox"/> Alternative Medicine <input type="checkbox"/> Enhanced Vision			
Dependent 2 Name (Last, First MI)		Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child
Dependent 2 is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental – If Assurant, Dental Office # (if different from employee): _____ <input type="checkbox"/> Alternative Medicine <input type="checkbox"/> Enhanced Vision			
Dependent 3 Name (Last, First MI)		Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child
Dependent 3 is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental – If Assurant, Dental Office # (if different from employee): _____ <input type="checkbox"/> Alternative Medicine <input type="checkbox"/> Enhanced Vision			
Dependent 4 Name (Last, First MI)		Date of Birth	Relationship <input type="checkbox"/> Child <input type="checkbox"/> Legal Dependent <input type="checkbox"/> Dom Partner Child
Dependent 4 is covered on the following plan(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental – If Assurant, Dental Office # (if different from employee): _____ <input type="checkbox"/> Alternative Medicine <input type="checkbox"/> Enhanced Vision			

Additional dependents may be listed on a separate page.

AUTHORIZATION: By execution of this enrollment form, I understand that I may not change the election during the coming year except in the event of a life change. I authorize the City of Scottsdale to make the necessary before-tax and after-tax payroll deduction(s). I also understand that I am responsible for reimbursement to the City for any benefit amount paid to me/for me in advance of my payroll deduction. By my signature, I certify that the information on this form is true and correct, and that the listed dependents are eligible for coverage under the plan.

Signature _____

Date _____

QUALIFIED LIFE STATUS CHANGES

You may not make changes to your benefit plans until the next open enrollment unless you experience a qualified life status change such as the birth of a child, marriage or divorce. If you experience a qualified life status change, you may add or cancel dependents but you may not change plans. You must notify HR within 30 days of a qualifying life status change. It is your responsibility to notify HR when a dependent (spouse/domestic partner or child) is no longer eligible for coverage. Failure to cancel an ineligible dependent from your coverage within 30 days will make you responsible for any claims incurred by an ineligible dependent and may result in disciplinary action up to and including termination.